your health

N E T W O R K

A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS

December 2008 Volume 16, Number 2

inside

Benefit Changes for 2009

During this year's annual transfer period, participants were provided with information regarding benefit changes which will be effective for 2009. For all healthcare options, the Insurance Committees adopted a balanced approach of moderate premium increases and benefit changes. This approach places more of the cost of healthcare services on the participant in the form of slight increases in deductibles and copays rather than leaving benefits constant and increasing premiums even more for all participants, regardless of the number of services they use. Please refer to the chart below for a summary of benefit changes.

	BENEFIT	CHANGE FOR 2009
PPO	Annual Medical Deductible	Increase to $350 per individual and $875 family
	Annual Medical Out-of-Pocket Maximum	Increase to $1,350 per individual and $2,700 family (in-network); $4,050 per individual and $8,100 family (out-of-network)
	Annual Pharmacy Copay Maximum	Increase to $1,620 per individual
POS	Physician Office Visit (In-Network)	Increase to $25 copay general; $30 copay specialist
	Chiropractic Care	Increase to $25 copay per visit
HMO	Physician Office Visit	Increase to $20 copay PCP; $25 copay specialist
	Chiropractic Care	Increase to $20 copay per visit
PPO, POS, HMO and PPO Limited	Emergency Room Use	Increase to $75 per visit
	Prescription Drugs	Increase to $25 for preferred brand and $50 for non-preferred
	Diabetic Supplies	Copay/coinsurance waived when using in-network provider
	Diabetic Prescription Drugs	Copay waived for generic and preferred brand when using in-network pharmacy

Dependent Eligibility Verification

In the July issue of *Your Health Network*, we announced an upcoming eligibility verification of dependent coverage. While our office anticipated beginning this review process in January 2009, the start date has been delayed until later in the year.

When this process begins, all participants with dependent coverage will be asked to provide documentation verifying the eligibility of all covered dependents. Policy holders will be provided with a list of their covered dependents, a worksheet to assist in determining the eligibility status of their dependents and a list of appropriate documentation which may be provided to establish eligibility by dependent category. In addition, we will begin requiring documentation regarding the eligibility for all new dependents being enrolled once the verification process begins.

As a reminder before the review begins, the following individuals are eligible for dependent coverage on your policy:

- Legally married spouse
- Natural child
- Legally adopted child
- Stepchild for whom you or your spouse has legal or joint custody or shared parenting
- Any child living in your home for whom you are the legal guardian
- Any child living in your home who you claim as a dependent on your federal income tax return

Dependent children are eligible for coverage until age 19. Dependents age 19 to 24 may only continue coverage if unmarried and either a full-time student or claimed on your federal income tax return.

Once your dependent no longer meets these eligibility guidelines, it is your responsibility to notify your agency benefits coordinator to terminate coverage. If you would like to verify the dependents currently insured under your policy, your benefits coordinator can provide you with this information as well.

The following individuals are ***not*** eligible for coverage as your dependent:

- Ex-spouse (even if court ordered)
- Parents of an employee or spouse
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

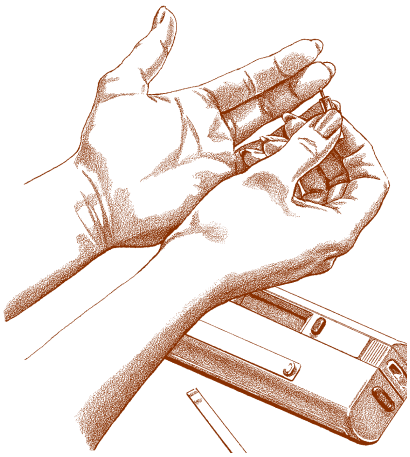
Please refer to your *Insurance Handbook* for further information on dependent eligibility. Thank you for your assistance and cooperation during this upcoming review.

Diabetes Benefit Enhancement

During this year's annual transfer period, plan members were provided information regarding the removal of the copayment and/or coinsurance for diabetic supplies and prescription medications. Beginning in January 2009, there will be no charge to plan members when purchasing diabetic supplies (i.e. glucose strips, syringes, lancets) or prescription drugs (oral and insulin) when using in-network providers.

Diabetes is the sixth leading cause of death in the U.S. and is the leading cause of non-traumatic amputations, blindness among working-aged adults and end-stage renal disease. The extent of diabetes in Tennessee is reflected in the state sponsored plans. In 2007 there were approximately 24,000 members, or 12.4 percent of our insurance population, who incurred $12.5 million in claims specific to diabetes. Total claims cost for these individuals were $211.3 million or $8,800 per diabetic member.

Effective and economical strategies exist for controlling diabetes and preventing serious complications such as those mentioned above. These strategies include controlling glucose, lipid and blood pressure levels, getting



regular foot and eye exams and getting an annual flu vaccine.

A number of employers are initiating "value based" benefits for the purpose of removing barriers to care for members with specific chronic diseases. Removing these copayments for individuals with diabetes has shown an increase in compliance with the strategies previously mentioned.

If you have been diagnosed with diabetes, be sure to follow your doctor's instructions to keep your condition under control. Proper monitoring of your condition now can help prevent serious complications in the future.

notable

Based on the recent procurement for the basic term life and special accident coverages provided to state plan members, Fort Dearborn will continue to administer these coverages.

For state employees with access to the new Edison system, we would like to advise you that the beneficiary information listed in the system pertains to savings bonds beneficiaries only. Edison will not record beneficiaries for any other benefits programs such as life insurance, savings plans with Great West, retirement or leave balances.

Retiring state plan members enrolled in long-term care coverage who wish to have the premium deducted from their retirement check need to contact MedAmerica at 1.866.615.5824 and request a "change of employment status" form. Completing this particular form will ensure a smooth process.

Under state law, individuals going through a divorce are not permitted to remove any dependent spouse (without permission of the court) until the divorce is final — regardless of the grounds on which the divorce is filed.

Beginning in 2009, BlueCross BlueShield and Cigna will review certain non-routine advanced radiological imaging diagnostic services and the setting for such services to determine medical appropriateness and necessity before the services are performed. Services subject to such review include magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectroscopy (MRS), computerized tomography (CT) computerized tomography angiography (CTA), positron emission tomography (PET) scans and nuclear cardiac imaging studies. Your doctor's office will handle the necessary arrangements to request approval for these services.

New ID Cards to be Issued

Regardless of which healthcare option you are enrolled in or if you changed your coverage during this year's annual transfer period, all health insurance vendors will be issuing new ID cards for the 2009 plan year. This is due to the fact that certain copayments are printed on the card and this information must be updated to reflect the new rates which will go into effect at the beginning of 2009.

New cards should be received prior to January 1, 2009. If you do not receive a new card, it could be due to an incorrect home address. This type of information is not forwardable by the postal service and will be returned if your address is incorrect. You may verify your home address information by contacting your agency benefits coordinator.

Also remember, any time you need to order additional ID cards, you may do so by calling the insurance company or visiting their web site.

Always present your ID card when seeking healthcare services to ensure you receive the maximum benefit of your plan.

State Employees May Forfeit Premiums

The flexible benefits program allows full-time state employees to pay health and/or dental insurance premiums before taxes are deducted. This premium conversion option is automatic for state employees enrolled in a medical or dental plan offered through the state group insurance program.

Since premiums are paid from pre-tax dollars, Internal Revenue Service (IRS) rules do not allow cancellation of coverage during the year unless an employee experiences a family status change like death, divorce, birth or adoption of a child, or a job change by the employee or the employee's spouse. Employees who voluntarily request termination of their insurance coverage without first getting approval to do so through flexible benefits will forfeit insurance premiums for the remainder of the year.

The process for requesting termination or cancellation of coverage is simple. Necessary forms (including the *Enrollment/Change Application* and the *Family Status Change Application* with supporting documentation attached) should be submitted together. These forms are available from your agency benefits coordinator. Examples of supporting documentation include marriage, birth, or death certificates, divorce decrees, notices of legal separation, proof of change in spouse's employment, and adoption papers.

Through the end of 2008, family status change requests will continue to be processed by the flexible benefits office in The Department of Treasury. Effective January 1, 2009, you ***must submit*** requests to Benefits Administration as our office will assume this responsibility.

Important reminders

- Always keep copies of the paperwork submitted.
- Termination shall take effect at midnight on the last day of any subsequent month in which the cancellation is requested.
- An employee who wishes to re-enroll at a later date will be subject to late applicant requirements.

Is the cost for a flu or pneumonia vaccination covered under my health plan regardless of where I receive it?

It's that time of the year again. The leaves have fallen, the holidays are here, and flu season awaits.

You may have heard advertisements encouraging you to get your flu shots and pneumonia vaccines through the pharmacy at your local grocery store or drugstore. Some stores without pharmacies offer flu shot clinics. The ads appeal to persons seeking convenient services without the need to schedule an appointment.

You should know that although vaccinations may be administered by certified pharmacists, the services you receive at grocery store and drugstore locations may not be covered by your insurance. You will be responsible for any non-covered charges, which may include the administration fee for the vaccine.

Eligible expenses will only be covered by your insurance plan if considered medically necessary and billed by an eligible provider. Contact the toll-free member service number on your insurance ID card with coverage questions prior to receiving vaccinations at locations other than your doctor's office.

Late Applicant Process Continues for 2009

Under the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA), group health plans must generally comply with the requirement of non-discrimination against individual participants and beneficiaries based on health status. However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from these requirements for self-funded options. All of the state-sponsored health options are self-funded; therefore, the State of Tennessee has elected to exempt the plans from the prohibitions against discriminating against individuals and beneficiaries based on health status in order to allow medical underwriting through a late applicant process.

By requesting this exemption, the state-sponsored plans will be able to continue the process that allows an eligible individual, who is not presently enrolled (late applicant), to enroll in the plan through a medical underwriting or proof of insurability process. The exemption from this federal requirement will continue for the plan year beginning January 1, 2009, and ending December 31, 2009. The election may, but is not required to be, renewed for subsequent plan years.

Eligible employees may apply for coverage for themselves and/or their eligible dependents by submitting medical information about each applicant. Employee eligibility must be verified by the employing agency and a non-refundable $60 application fee is required. Applications may be obtained from your agency benefits coordinator or you may print a copy from our web site at www.tn.gov/finance/ins/ from the publications and forms page.

This enrollment process is in addition to the special enrollment provision process for those who lose their health coverage due to a HIPAA qualifying event. Please see your *Insurance Handbook* for a list of qualifying events. In these instances, the medical underwriting process is not necessary. The special enrollment provisions require that application for coverage be made within 60 days of the qualifying event by submitting an *Application for Special Enrollment by Qualifying Event* and an *Enrollment/Change Application*.

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, a group health plan participant who is receiving benefits in connection with a mastectomy is entitled to coverage for the following services:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's attending physician.

Coverage for the mastectomy-related services or benefits required under the "Women's Health Act" will be subject to the same deductibles and coinsurance or copayment provisions that apply with respect to other medical or surgical benefits provided.

If you have any questions about your healthcare option, please call the customer service number on your member identification card.

Don't Wait Until the Last Minute

Have you ever gotten to the bank just as they were locking the doors or visited a favorite store to find the parking lot vacant and the store dark and uninviting — a "closed" sign on the door? Imagine how you'd feel if you completed paperwork to make changes to your insurance coverage only to find that you were too late. This can happen if Benefits Administration doesn't receive your paperwork within the allowed time frame.

Enrolling in insurance coverage and making changes to your coverage is a vital part of your insurance benefits. All agencies participating in the state sponsored insurance plans have agency benefits coordinators who can assist you with completing required forms and submitting the appropriate paperwork. Make sure to allow them the time they need to review your paperwork and gather any missing information before they send it on to Benefits Administration.

It's a good idea to have your paperwork to your agency benefits coordinator at least ten days before the deadline. For example, if the time frame for submitting paperwork is 60 days, get it to your benefits coordinator within 50 days. If you wait until the last few days before the deadline, there's a chance your agency won't be able to get it in to Benefits Administration within the required time frame, and the changes you have requested will be denied.

Contact your agency benefits coordinator for specific information regarding changes to your enrollment, including required forms, supporting documentation that must accompany requests and applicable deadlines.

Following are some important deadlines to keep in mind when requesting changes to your coverage.

Adding Dependents

You have 60 days from the date the dependent is acquired to submit the necessary forms to add the new dependent. To add a spouse to coverage, the acquire date is the date of marriage. To add a dependent child to coverage, the acquire date is the date of birth, change of student status, or, in case of adoption, the legal obligation and support of such child.

Terminating Dependents

The request to terminate coverage for a dependent who no longer meets eligibility guidelines must be submitted immediately upon the date of the loss of eligibility. Coverage will terminate at the end of the month in which the dependent ceases to be eligible. Claims paid in error for any reason will be recovered from the employee. If you fail to submit a written request for termination in a timely manner, you will only receive a three-month refund of your portion of the premium from the date of notification to your agency. If you owe the plan for claims paid inappropriately, any overpaid benefits above your refund amount will be billed to you.

Late Applicant Medical Underwriting

Individuals who do not apply during their initial eligibility period may apply for approval through the medical underwriting process. After the review is complete, the applicant will be notified by letter of the underwriter's decision. Individuals must submit the required forms and documentation within 60 days of the date of an approval letter.

Late Applicant Special Enrollment Provision

Eligible employees or dependents who lose health coverage from another source due to certain qualifying events, such as divorce, death, termination of employment, may apply through the special enrollment process. The required forms and documentation must be submitted within 60 days of the loss of insurance coverage.

For further information please refer to your *Insurance Handbook*. A copy is available from your agency benefits coordinator or you may access the handbook from our web site.

Your EAP Benefits

The Employee Assistance Program (EAP) is a consultation service for employees and their eligible dependents who may be experiencing personal or work place problems. Everyone has problems from time to time. Usually we work them out. But sometimes problems persist, becoming serious enough to affect us both on and off the job. At such times, an EAP counselor may be able to help.

As soon as you feel that a problem is getting too difficult to handle alone, call Magellan Health Services toll-free at 1.800.308.4934 any time of the day, any day of the year. Counselors are specially trained in EAP work. They handle delicate issues and they have the knowledge and skills to assist you toward solving your problems.

Your EAP benefit provides for up to six sessions with a Magellan counselor per problem episode. These visits are provided at no cost to you; however, sessions must be pre-authorized by calling Magellan.

As part of your EAP benefit, we also encourage you to discover Magellan's internet-based services. Visit www.magellanhealth.com for confidential and anonymous access to a wide variety of information, available at no cost. For further information call 615.741.1925.

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